Iowa Get Screened

Colorectal Cancer Program

Information Manual

2010-2015

Iowa Get Screened is a program of the Iowa Department of Public Health, which provides colorectal cancer screenings to low-income, uninsured and underinsured Iowans.

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Introduction:

The Iowa Get Screened Information Manual outlines objectives and requirements of the Iowa Get Screened (IGS): Colorectal Cancer program. This manual serves as a resource for participating IGS local programs and enrolled health care providers who provide screening and diagnostic services to program eligible men and women.

The purpose of this manual is to provide partners with:

- A program overview;
- Local program responsibilities;
- Client eligibility requirements;
- Health care provider roles and responsibilities; and
- Information on reimbursable/non-reimbursable program services.

Vision:

All men and women shall have access to colorectal cancer screening, while reducing the number of individuals being diagnosed with colorectal cancer.

Mission:

The Iowa Get Screened: Colorectal Cancer program is committed to raising awareness, promoting colorectal cancer screening and fostering system change in an effort to save lives from one of the deadliest, yet most preventable diseases.

Confidentiality Statement:

The Iowa Get Screened (IGS): Colorectal Cancer program endorses the health care standards of participant confidentiality. These standards apply to all individuals and agencies representing or working in any capacity with IGS. Any information gathered will be used only for program purposes and no participant will be identified by name without written permission.

Confidentiality is both an ethical and legal responsibility. State and federal courts uphold the common patient confidentiality standards such as the American Medical Association (AMA) 'Code of Ethics.' Divulging medical information (verbal, written, phone, fax, electronic, etc.) to a third party without appropriate consent from a participant considered a breach of confidentiality whether intentional or unintentional.

All participant records and identifying information must be secured in a manner accessible only by IGS staff. This includes but is not limited to locking files, providing a private area for verbal communication with participants (face-to-face or by telephone) and a method for securing participant information.

SCREENING RECOMMENDATIONS

The United States Preventive Services Task Force (USPSTF) recommends screening for colorectal cancer in adults beginning at age 50 years and continuing until age 75 years using any of the following three regimens:

1) High-sensitivity Fecal Occult Blood Testing (FOBT) or Fecal Immunochemical Test (FIT), annually;
2) Sigmoidoscopy, every 5 years combined with high-sensitivity FOBT or FIT every 3 years; and
3) Screening colonoscopy at intervals of 10 years.

For more details regarding the USPSTF recommendations, visit:
http://www.uspreventiveservicestaskforce.org/uspstf08/colocancer/colors.htm.

NOTE: Although the USPSTF recommends screening for individuals between the ages of 50-75; the IGS program serves individuals ages 50-64. Persons out of the age category 50-64 are not eligible for the program. The primary screening test used in IGS is the FIT (average risk individuals), followed by the colonoscopy (increased risk individuals) and Double Contrast Barium Enema (only as a last choice/ alternate method). Any other screening test will not be reimbursed by the program.

PROGRAM OVERVIEW

The Centers for Disease Control and Prevention (CDC) launched the Colorectal Cancer Control Program (CRCCP) in 2009. At that time funding was granted to twenty-two states and tribes across the

United States. In Iowa, the program is referred to as the Iowa Get Screened (IGS): Colorectal Cancer Program. The IGS Program provides services through select community health centers, local *Care for Yourself, Breast and Cervical Cancer and WISEWOMAN* Programs.

The overarching goal of the Iowa Get Screened program is to increase the reported colorectal screening rate within the state of Iowa from 64% to 80% by the end of 2014. The focus of the program consists of screening targeted populations, promoting policy and system change and providing awareness and education.

Populations Served by IGS	
Male and Female Iowa Residents	• Age 50 – 64 years
	• Uninsured • Underinsured
	• Household income of up to 250% FPG
	• Average or Increased Risk for colorectal cancer

Long-term program goals include: attaining screening coverage for a limited percentage of the state's eligible uninsured/underinsured population, contributing towards increasing population-level colorectal cancer screening rates and reducing health disparities in colorectal cancer screening, incidence and mortality.

Program Partners

IGS Program
The IGS program is administered by the Iowa Department of Public Health (IDPH) through the Bureau of Chronic Disease Prevention and Management. IDPH receives funding through a competitive cooperative agreement process from the Centers for Disease Control and Prevention for a period of

6/30/09-6/29/14. A one-year extension was granted for the period of 6/30/14-6/29/15. Renewal of annual funding through this cooperative agreement is dependent upon available funding.

Medical Advisory Board

The Medical Advisory Board (MAB) is made up of a diverse group of professionals (e.g. primary care providers, nurses, endoscopists, oncologists, pathologists, radiologists, coordinators and patient navigators) who offer their expertise from the time of screening to diagnosis to treatment, offering a continuum of care. The MAB provides oversight of the quality of screening services delivered throughout the five-year funding period. The primary role of the MAB is to:

1. Assist in the establishment of program eligibility criteria (e.g., defining underinsured, establishing guidelines for diagnostic testing, surveillance intervals, etc.)
2. Monitor quality of screening, rescreening, diagnostic and surveillance services
3. Assist with identification of resources for treatment and referral of clients that are ineligible for the program
4. Provide direction on individual program policy development and data collection

University of Iowa Center for Public Health Statistics at the College of Public Health

Their data and research team has worked with the IDPH staff to develop the Iowa Get Screened data system. The data and research team also provides troubleshooting, data analysis and updates on the data system.

Mercy Clinical Laboratory

Orders and processes Fecal Immunochemical Tests (FIT's) for the IGS program.

Local Program

The programs contracting with IDPH to provide Iowa Get Screened program services.

Participating Health Care Provider

The individual health care providers or provider entities that have signed a provider/cooperative agreement with IDPH. The signed agreement allows IDPH's third-party billing company (Provider Claim Systems) to accept service claims and provide reimbursement to participating providers.

Patient Navigator Services

Through a partnership with the American Cancer Society, the IGS program provides patient navigation services to facilitate access to medical care for persons identified with cancer *(see appendix H)*. The primary purpose of the navigator is to improve health care delivery to populations who have limited or no access to the health care system. The role of a patient navigator is to eliminate barriers and guide participants through the medical system in a culturally sensitive manner. Patient navigation services will identify and coordinate resources for the patient who may require physical, emotional, financial or other support through their cancer journey.

Third-Party Billing Company

The third-party billing company for IGS is Provider Claim Systems (PCS). Further information about PCS can be found in the *Reimbursement* section of this manual.

Lori Wink
Provider Claim Systems
PO Box 1608

Mason City, IA 50402-1608
(P) 1-800-547-6789 Ext. 34
(E) lwink@nicao-online.org

LOCAL PROGRAM RESPONSIBILITIES

Local program responsibilities include:

1. Recruitment of providers
2. Recruitment of participants
3. Eligibility determination
4. Enrollment
5. Case management services
6. Follow-up care
7. Documentation, tracking and data reporting
8. Rescreening
9. Billing and Reimbursement

1) Recruitment of Providers

Each local program is responsible for building a relationship with health care providers in their area who could potentially provide services as part of the IGS program. All providers, provider offices, pharmacies, etc. that are going to be providing services through the IGS program and getting reimbursed by Provider Claim Systems need to have a signed IGS Provider/Cooperative Agreement with IDPH. Each facility gets one agreement. For example, if multiple providers will be participating in the program, but they're located in one facility, that facility only has to fill out one agreement listing all participating providers on the application. Depending on how each provider group prefers to deliver services, the number of enrolled providers can vary. It is encouraged that each local program limit the amount of enrolled providers to help assure that participants don't get billed for services due to lack of consistency of education to providers.

In order to become an enrolled provider, a local program coordinator will need to send each provider group a copy of the IGS CPT codes (Appendix D), along with an IGS Cooperative/Provider Agreement that the provider group will need to fill out, sign and mail back to IDPH/IGS staff prior to providing services.

Once a provider group is enrolled, each IGS Coordinator will need to communicate with them to determine the referral process that works best (e.g. fax/phone referral, etc). Please visit the *Health Care Provider* Section of the manual for more specific information regarding recruitment of providers.

(2) Recruitment of Participants

Participants will be recruited using in-reach strategies within *Iowa Care for Yourself (CFY) programs* and *Federally Qualified Health Center (FQHC)* sites. The income eligibility guidelines for IGS are the same as those for *CFY* services. Screening will be offered to eligible Iowans who have average risk or increased risk for colorectal cancer.

3) Eligibility Determination

Average Risk

Iowa Get Screened efforts are focused on individuals between the ages of 50 and 64 years old who are at average risk for colorectal cancer. Average risk is generally defined as:

- No personal or family history of CRC or adenomas
- No history of inflammatory bowel disease (Ulcerative Colitis or Crohn's disease)
- No history of genetic syndromes such as familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (HPNCC)

Increased Risk

Individuals at increased risk for colorectal cancer may be eligible for screening or surveillance.

- **Eligible for CRC screening or surveillance:**
  - A family history of CRC or adenomatous polyps
- **Eligible for surveillance with colonoscopy only:**
  - A personal history of adenomatous polyps on a previous colonoscopy
  - A personal history of colorectal cancer

High Risk

People at high risk for CRC are not eligible for screening or surveillance services through the Iowa Get Screened program. They must be referred to appropriate services. People at high risk for CRC include:

- A genetic diagnosis of familial adenomatous polyposis (FAP) or hereditary non-polyposis colorectal cancer (HNPCC)
- A clinical diagnosis or suspicion of FAP or HNPCC
- A history of inflammatory bowel disease (Ulcerative Colitis or Crohn's Disease)

Current Significant Gastrointestinal Symptoms

People with the following gastrointestinal symptoms are not eligible for screening services through the Iowa Get Screened program:

- Rectal bleeding, bloody diarrhea, or very dark blood in the stool (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving IGS screening services)
- Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated)
- Persistent/ongoing abdominal pain
- Recurring symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation)
- Significant unintentional weight loss of 10% or more of starting body weight *(Example: If a person weighs 150 pounds, 10% of his/her body weight is 15 pounds)*

For more specific and detailed information regarding IGS eligibility, please visit Appendix E & F to view the *Patient Eligibility & Screening Determination* form and accompanying flowchart.

NOTE: All Iowans who present to the program for screening services and are found to be ineligible must be referred to additional resources/services. People presenting with the symptoms listed above need a complete evaluation by a clinician to determine the cause of their symptoms. This evaluation, and any potential subsequent treatment, is beyond the scope of this program. If a client has been medically evaluated and cleared for colorectal cancer screening, the client may then enroll in the program if all eligibility criteria are met.

4) Enrollment

Participants will enroll for colorectal cancer screening services at a participating IGS local program. The local program will determine eligibility. Eligibility screening will not be the responsibility of the health care provider. Iowans that meet the client eligibility criteria below are eligible to enroll in the Iowa Get Screened Program.

Prior to being considered a participant, individuals enrolling in this program must:

- Have a primary care provider
- Meet the eligibility criteria and
- Be given the opportunity to:
  1. Have the *Informed Consent and Release of Medical Information* form explained to them;
  2. Sign the consent form; and
  3. Must agree to participate – make a commitment to complete screening.

NOTE: An individual does not need to prove his/her income; you may accept his/her self-report.

5) Case Management Services

The goals of using a case management system for patient services are to assure participants:

- Receive program information and colorectal cancer educational materials;
- Are assisted to reduce barriers to screening per individual need, examples may include: fears, cultural beliefs, language, transportation, understanding of information, etc.;
- Receive guidance throughout the screening, diagnostic and treatment processes;
- Understand colorectal cancer screening procedures and provider recommendations; and
- Receive appropriate services according to diagnosis including follow-up.

Patient support services begin when an individual is deemed eligible for IGS Program services and enrolls with a local program.

IGS Case Management Process

1. The local coordinator screens an individual for IGS program eligibility using the *Patient Eligibility & Screening Determination* form
   - If eligible, and the individual agrees to participate in the program, the local coordinator has the individual
     - Sign a *Consent & Release of Medical Information* form;
     - Fills out and gives them a participant ID card for them to bring to their appointments;
     - Enters they're enrollment into the IGS data system*;*
     - Enters their basic information into the Provider Claim Systems data base; and
     - Provides case management for them throughout the screening and/or diagnostic process.
   - If ineligible, the local coordinator fills out a *Client Ineligibility* form and refers the participant to his/her primary care provider (if at a high risk for developing colorectal

cancer) or gives them colorectal cancer educational materials (if at an average risk for developing colorectal cancer)

2. Once entered into the data system, the local coordinator goes over program details with the individual including the process/instructions for doing the Fecal Immunochemical Test (FIT)
    - Coordinator completes test tube information and green sections on the lab requisition form. The patient completes the yellow section of the form.
    - Patient obtains stool sample and sends in the mail along with the Lab Requisition form (this form must be included).
    - The sample has to be back to the lab within 7 days of obtaining the stool or it's not viable.
3. The local coordinator makes a follow-up call to the individual within 3-4 days following enrollment to be sure they mailed the FIT in and/or to answer any follow-up questions.
4. FIT results are faxed to the local program and to IDPH from the Mercy Clinical Laboratories where they are processed. If a coordinator does not receive results for a patient, they should notify an IGS state staff person. If state staff don't have the results, they will check with the lab.
5. FIT results are communicated to the participant by the local coordinator or the referring physician listed on the Lab Requisition form.
6. If the results are negative/normal, the information can be entered into the IGS data system. The coordinator will complete the FIT data screen and Final Diagnosis data screen in order to close the cycle.
7. If the results are positive/abnormal, the coordinator will enter the results into the IGS data system and refer the participant to an enrolled health care provider for a colonoscopy
    - Each county/provider facility is different in how they prefer the referral process to go….the local coordinator will want to be in touch with the provider office ahead of time to work out a referral system that works best for each of them. They will want to establish how the referral will be communicated to the provider office (phone, fax, etc), whether the provider wants to have initial consultations/office visits with the participant prior to the procedure, who will call in the colon prep kit to the enrolled pharmacy, how the results will be communicated back to the local coordinator, etc.
8. Following the colonoscopy, the coordinator will follow-up with the provider that performed the colonoscopy for the results if they weren't already sent to them.
9. If the results are normal/negative, the coordinator enters the results into the data system. The coordinator will complete the Colonoscopy data screen and Final Diagnosis data screen in order to close the cycle
10. If the results are abnormal/positive for a CRC diagnosis and treatment services are required, the participant's provider will perform a consultation in order to educate the participant on treatment options.
    - The IGS Local Coordinator will fill out and fax a Patient Navigation referral form to the American Cancer Society to initiate Patient Navigation services for the participant if he/she agrees to treatment services (see Appendix H for the Patient Navigation form).

- The IGS local coordinators, in partnership with the health care provider and patient navigator, will assist individuals needing treatment in finding a nearby hospital/cancer treatment center.
- Hospital/cancer treatment center staff will assist the participant in obtaining treatment services at an affordable cost based on the individual's annual income and ability to pay for services.

11. Participants who were screened through the IGS program and did not require treatment for CRC, will receive a colorectal cancer screening reminder approximately one year from the original FIT screening date, or whatever timeframe recommended by the endoscopist for individuals who received a colonoscopy. These reminder letters will be mailed to the patient from IDPH; however, they will look like they are coming from local programs. At that time the participant will be re-evaluated for IGS program eligibility.
12. Individuals who are at high risk are <u>not</u> eligible for the program. We would recommend referring them to the Colon Cancer Foundation of Iowa. A colonoscopy application can be found at: http://www.coloncanceriowa.org/scope-it.html.

Participants with an abnormal screening result must receive a final diagnosis within 90 days of the screening test. Participants diagnosed with colorectal cancer must begin treatment within 60 days of their diagnoses.

6) Follow-up Care

Following a FIT screening, it is the responsibility of the local program coordinator to follow-up with the patient regarding results and next steps. Following a colonoscopy, the provider who performed the procedure will be in charge of communicating those results and sending them to the local coordinator to assure they are entered into the data system accurately by the coordinator. The coordinator and provider will determine a process that works best as far as who contacts the patients with results.

7) Documentation, Tracking and Data Reporting

Local programs are required to enter data into the IGS data system corresponding to each service the participant receives (e.g. enrollment, FIT, colonoscopy, etc).

IGS local programs are responsible for tracking their own program progress using the IGS data system. The "reports" tab allows programs to determine open cycles, enrollment progress, data errors, etc. For data system questions, contact Jenny Hodges 515-281-4779 or Karen Ullom 319-335-6866.

8) Rescreening

If results are negative/normal, the local coordinator will notify the participant and enter information into the data system. IDPH will contact local programs to assure participants are sent a reminder for their next screening cycle. For each subsequent cycle, eligibility determination must be confirmed and a new cycle must be created in the data system.

9) Billing & Reimbursement

<u>Vouching/Reimbursement</u>

Typically, vouching/reimbursement for IGS services are done on a monthly basis; however, this can be done altogether in one submission if that works easier for the local program. Everything that's listed in

your contract budget can be reimbursed for using the General Accounting Expenditure (GAX) form and Contract Expenditure Report form (if you need to add more columns to the Expenditure Report form, feel free to tailor it). If you never received these forms or if you need another copy of them, contact Jenny Hodges: Jennifer.Hodges@idph.iowa.gov. Once you've filled the two forms out and signed, the original copies can be mailed back to:

Jenny Hodges
Lucas State Office Building
Iowa Department of Public Health
Bureau of Chronic Disease Prevention & Management
321 E. 12th St
Des Moines, IA 50319

Provider Claim Systems

Provider Claim Systems (PCS) is the IGS third-party billing company. They reimburse for covered program services that are not part of the program contract. This includes: the FIT processing cost, colonoscopy services costs (including services related to the colonoscopy such as pathology), office visits and pharmacy fees.

In order to assure that providers get reimbursed through our program, it's important that all participants are entered into the PCS data base, which is a different system than the IGS data system. Once you enter a participant into the IGS data system, there's one more step that you need to take and that is entering the patient's demographic information into the PCS data base/website: https://www.nicao-online.org/pcs/. The PCS link is included on the bottom of the enrollment screen in the IGS data system to remind coordinators of that extra step. Entry of a participant into PCS is a very quick and easy process.

NOTE: Any participant who is not enrolled into the PCS data base (in addition to our IGS data system), will not be recognized as an eligible participant by PCS; therefore, any claims submitted for them to PCS will be denied. This would include FIT processing and endoscopy-related claims. Also, any provider group who has not completed a Provider/Cooperative Agreement with IDPH/IGS will be denied reimbursement by PCS for IGS-related services. Questions about claims should be directed to Lori Wink with PCS at (800) 547-6789 ext. 34.

IOWA GET SCREENED SCREENING METHODS

Routine screening and early detection are vital to reducing morbidity and mortality from colorectal cancer. Screening can detect precancerous polyps-abnormal growths in the colon or rectum-which can be removed before turning into cancer. Recommended colorectal screenings beginning at age 50 increase the chances of not only finding the disease early, when it's highly treatable, but screening can actually help to prevent the disease. The U.S. Preventive Services Task Force (USPSTF) recommends

A health care provider's recommendation is the most effective method to encourage men and women to get regular cancer screening tests and exams.

screening for colorectal cancer using high-sensitivity fecal occult blood testing, sigmoidoscopy or colonoscopy beginning at age 50 years and continuing until age 75 years.

IGS encourages individuals to obtain health services regularly and to schedule a colorectal cancer screening beginning at age 50; screening should begin at a younger age for individuals who have a family history of colorectal cancer or precancerous polyps. Regular screening and early detection are fundamental to reducing morbidity and mortality rates of colorectal cancer.

The Fecal Immunochemical Test (FIT), also referred to as immunochemical Fecal Occult Blood Test (iFOBT), should be used as the primary screening method and colonoscopy as the secondary method in the IGS program. A colonoscopy can be used as the initial screening test only when an individual enters the program at an increased risk for colorectal cancer. Double Contrast Barium Enema (DCBE) will be reimbursed by the IGS program only when recommended by the provider as an alternative screening method. Otherwise, any other colorectal screening test besides a FIT or colonoscopy will not be reimbursed by the IGS program.

Fecal Immunochemical Test: uses antibodies to detect blood in the stool. The IGS participant will receive a test kit from their local coordinator (these kits will be purchased and distributed to local programs by the state IGS staff). At home, the individual uses a stick or brush to obtain a small amount of stool. The participant will then send their test kit to the University of Iowa Diagnostic Laboratory (accompanied by the Lab Requisition Form) where the stool samples will be checked for the presence of blood. For an average risk participant, it is recommended that the FIT test is administered annually.

Colonoscopy: the direct examination of the entire colon. Costs associated with colonoscopy (provider, facility and pathology) are reimbursed by the IGS Program at Medicare Part B rates. The goal during a colonoscopy is that all lesions identified as cancer or polyps be excised or, if too large for excision, biopsied, and sent for pathologic examination. Pathologic evaluation of colonic polyps is critical to determine the individual risk category for colorectal cancer, the first-degree relative's risk of colorectal cancer and the proper interval for repeat colorectal cancer testing. An "adequate" colonoscopy is one that reached the cecum and has visualized over 90% of the colonic mucosal surface. For an average risk participant, it is recommended that a colonoscopy is administered every 10 years beginning at age of 50. **Fecal Immunochemical Tests do not need to be administered on patients during that 10-year timeframe.**

Note: There will be no reimbursement to providers for colonoscopies or related costs performed prior to the IGS enrollment start-date. People at higher risk of developing colorectal cancer should begin screening at a younger age, and may need to be tested more frequently. The decision to be screened after age 75 should be made on an individual basis with the provider and/or endoscopist. Persons out of the 50-64 age category are not eligible for the program.

SURVEILLANCE

Surveillance is defined as periodic colonoscopy on a person who has a prior history of adenoma(s)/precancerous polyps. The timing of surveillance colonoscopy after polypectomy depends on the size, type, histology, number and completeness of polyp removal during the initial colonoscopy. Surveillance after surgical resection of colorectal cancer depends on whether the cancer resulted in obstruction of the bowel, and the presence of synchronous cancers or polyps on subsequent evaluations.

Surveillance recommendations should be made on a case-by-case basis by the provider, the program and the Iowa Get Screened Medical Advisory Board. Recommendations for surveillance should follow available guidelines.

COMPLICATIONS

Medical complications experienced by clients who have received a colonoscopy or DCBE either during, or within 30 days after the procedure, should be reported to the Iowa Department of Public Health within seven days of being reported. Reportable complications include bowel perforation, hemorrhage, prolapsed colon and intussusception. Confirmed complications that result in an emergency room visit, hospitalization or death should be reported to Jenny Hodges, IGS Screening Coordinator, at 515-281-4779.

FOLLOW-UP FOR ABNORMAL SCREENING TESTS

Participants with positive or abnormal screening tests must receive appropriate diagnostic procedures as determined by the program and the Medical Advisory Board. Participants with positive or abnormal Fecal Immunochemical Test must receive a complete colon examination with colonoscopy (preferred) or DCBE if recommended over the colonoscopy by the provider. It will be the responsibility of the local coordinator to notify the participant of the FIT results and refer them to a participating provider group for a colonoscopy. For questions on enrolled colonoscopy providers, contact IGS Screening Coordinator Jenny Hodges 515-281-4779.

Participants with an abnormal screening result must receive a final diagnosis within 90 days of the screening test. Participants diagnosed with colorectal cancer must begin treatment within 60 days of their diagnoses.

Participants diagnosed with colorectal cancer, or other cancers or medical conditions, must be referred out of the IGS program for appropriate treatment.

REFERRAL FOR TREATMENT

When treatment services are required, the participant's provider will perform a consultation in order to educate the participant on treatment options. The IGS program has an agreement with the American Cancer Society to provide Patient Navigation Services to IGS participants once they are diagnosed with cancer. Individuals who fall at or below of 200% of federal poverty guidelines may be eligible for the IowaCare program. IGS local coordinators will work with the individual to enroll in the IowaCare program if interested and eligible. The IGS local coordinators will also assist individuals needing treatment in finding a nearby hospital/cancer treatment center if they prefer that option. Hospital/cancer treatment center staff will assist the participant in obtaining treatment services at an affordable cost based on the individual's annual income and ability to pay for services. If a participant is diagnosed with colorectal cancer and the local program or provider staff would like recommendations/information about nearby cancer treatment centers, call IGS staff, Jeanna Jones at 515-242-6516, this information can also be found on the IGS website at: http://www.idph.state.ia.us/hpcdp/iowa_get_screened_resources.asp.

REPORTING RESULTS

Data Collection and Reporting

Iowa Get Screened is required to collect data and report on all services received through the program. CDC requires IGS to collect minimum data elements referred to as Colorectal Cancer Data Elements **(**CRCDE's). These elements will be accounted for when all the data is entered correctly into the IGS data system. They are mandatory for assuring funding is used to serve the designated population and that participants receive all appropriate services.

Adequate Colonoscopy

An adequate colonoscopy is defined as reaching the cecum and having colonic preparation sufficient to visualize 90% of the colonic mucosa. The colonoscopy procedure report should detail whether the cecum was reached and whether the endoscopist visualized the colonic mucosa adequately.

Findings of Colonoscopy

The endoscopist's report of colonoscopy findings should include documentation regarding polyp(s), mass, lesions/tumors, other lesions, hemorrhoida, diverticular disease, varices, inflammatory bowel disease, Ulcerative Colitis and/or Crohn's disease. The report should include:

- Number of lesions
- Description (e.g., flat, raised, sessile, pedunculated, bleeding, irregular, etc.), size and location of each lesion
- Biopsy/management of lesions:
  - Biopsy during the colonoscopy with removal of entire lesion(s)
  - Biopsy without removal of entire lesion(s)
  - No biopsy during colonoscopy
  - Other management of polyp/lesion (tattoo of site, saline prior to biopsy, etc.)
- Additional recommendations
  - Additional surgery or procedures needed (specify what is needed)
  - No need for additional surgery or procedures at this time

Endoscopist Recommendation

The date of the next colonoscopy and/or other testing is based on the findings of the colonoscopy and provider recommendation. If an individual enters the program at an increased level and is needing a follow-up colonoscopy, the local coordinator should obtain a copy of their previous colonoscopy report and use the provider's recommendation as guidance as to when the individual is due for their next screening. The coordinator should keep a copy of this report in their own files, as well as send one to IGS state staff to keep on file. **Fecal Immunochemical Tests should not need to be administered on patients who had a normal colonoscopy prior to their next scheduled colonoscopy.**

Follow-up of Inadequate Colonoscopy

If a provider determines that a colonoscopy is inadequate, the provider should determine if and when additional procedures are necessary to complete the screening. A follow-up colonoscopy due to an inadequate initial screening colonoscopy is reimbursable by IGS.

HEALTH CARE PROVIDERS

Enrolling a new provider group/facility

Each local program is responsible for building a relationship with health care providers in their area who could potentially provide services as part of the IGS program. All providers, provider offices, pharmacies, etc. that are going to be providing services through the IGS program and getting reimbursed by Provider Claim Systems need to have a signed IGS Provider/Cooperative Agreement with IDPH. Each facility gets one agreement. For example, if multiple providers will be participating in the program, but they're located in one facility, that facility only has to fill out one agreement listing all participating providers on the application. Depending on how each provider group prefers to deliver services, the number of enrolled providers can vary. It is encouraged that each local program limit the amount of enrolled providers to help assure that participants don't get billed for services due to lack of consistency of education to providers.

In order to become an enrolled provider, an IGS local coordinator will need to send the provider group a copy of the IGS CPT codes (Appendix D), along with an Electronic IGS Cooperative/Provider Agreement that the provider group will need to fill out, digitally sign and email back to IDPH/IGS staff prior to providing services. To obtain a copy of this agreement email Jenny Hodges @ Jennifer.Hodges@idph.iowa.gov.

Once a provider group is enrolled, each IGS local coordinator will need to communicate with them to determine the referral process that works best (e.g. fax/phone referral, etc). Below is an example of how the provider enrollment process could go:

- IGS local coordinator will identify and contact an endoscopist, colonoscopy facility (if different from where endoscopist is housed) and pharmacy to start off to see if they're interested in participating in the IGS program in that area. This conversation could include:
    - Brief program overview
    - What their role in the program would look like
    - Discussion of reimbursement-CPT Codes (Medicare Part B rate reimbursement)
    - Approximately how many individuals they might be serving
    - Length of time for the program/grant
- Once a contact person at the facility is established, the coordinator will want to follow-up with them in an email including a copy of the agreement and program CPT codes, recapping in the email what was discussed during the call.
- Once the provider office has the agreement, it can take a while to get all of the approvals in each facility and to get a final signature. Once you have a contact person within a facility, stick with them for all follow-up.
- Signed agreements are emailed to IDPH/IGS staff at the email listed above for the finalization process.
- IDPH/IGS staff enters the facility into the PCS system so they can be recognized as an IGS participating provider/reimbursable entity.

Updating Facility/Provider Information to an Existing Agreement

- If a facility has already signed an agreement with the IGS program, but needs to make changes (address, new provider, etc), they just have to fill out an *Update of Application for Provider Status* form and mail it back to IDPH/IGS staff. Contact Jenny Hodges to obtain a copy of the *Provider/Cooperative Agreement* or *Update of Application for Provider Status* form to send to a provider group.

REIMBURSEMENT SERVICES

Contract Reimbursement

Vouching through the Department: Vouching refers to submitting a claim for reimbursement for items outlined in local program contract budgets, which can include emergency barrier funding and case management rates. Vouching is encouraged on a monthly basis. A participant can only be vouched for after screening and diagnosis is complete and the final diagnosis has been completed in the IGS data system. All claim submission must be completed in the Grant Tracking Site located in www.IowaGrants.gov. For questions regarding vouching and/or Grants.gov contact Victoria Brenton @ Victoria.Brenton@idph.iowa.gov.

Provider Claim Systems Reimbursement

IDPH has contracted with a third party billing company, Provider Claim Systems (PCS), a division of North Iowa Community Action Organization, to process claims and reimburse health care providers and Mercy Clinical Laboratories for IGS covered services.

Federal law requires that reimbursement with federal funds may not exceed the published Iowa Medicare Part B Participating Provider rates. The current IGS Reimbursement Schedule/CPT codes list can be found in *appendix D*. Annual updates to the reimbursement schedule and codes list will be published separately from this document and emailed to local programs.

An individual enrolled in IGS should not be billed for: any covered program service.

Participants can be billed for non-covered services provided during an IGS visit; however, the participant needs to be notified beforehand that these additional services will be their responsibility. IGS is advertised as a free program and some participants may be confused if billed for additional services.

Enrolled provider groups/facilities have agreed to accept IGS rates as full payment for covered services as stated in the *Provider/Cooperative Agreement*. IGS will reimburse provider facilities the difference in what insurance has paid at the allowable rate. IGS can be billed at a provider facility's customary rate; however, they will be paid at the Medicare B rate. **No other CPT codes are accepted by our program and will be disallowed if billed.**

The following services are reimbursable at the Medicare Part B rate:

- Screening Tests and Procedures
  - Fecal Immunochemical Tests annually
  - Colonoscopy every 10 years (unless a provider recommends differently)
  - Biopsy/polypectomy during a colonoscopy
  - Bowel preparation
  - Moderate sedation for colonoscopy
  - Office visits related to above tests

- Diagnostic follow-up services
    - Office visits related to screening and diagnostic tests
    - Total colon exam with either colonoscopy (preferred) or DCBE
    - Biopsy/polypectomy during colonoscopy
    - Moderate sedation for colonoscopy
    - Bowel preparation
    - Pathology fees

The following services and/or scenarios are NOT reimbursable:

- Screening tests requested at intervals sooner than recommended by the Center for Disease Control and Prevention's national guidelines (unless a provider recommends differently)
- CT Colonography (or virtual colonoscopy) as a primary screening test
- Computed Tomography Scans (CTs or CAT scans) requested for staging or other purposes
- Surgery or surgical staging, unless specifically required and approved by the program's MAB to provide a histological diagnosis of cancer
- Any treatment related to the diagnosis of colorectal cancer
- Any care or services for complications that result from screening or diagnostic tests provided by the program
- Evaluation of symptoms for participants who present for CRC screening but are found to have gastrointestinal symptoms
- Diagnostic services for participants who had an initial positive screening test performed outside of the program
- Management of medical conditions, including Inflammatory Bowel Disease (e.g., surveillance colonoscopies and medical therapy)
- Genetic testing for participants who present with a history suggestive of a HNPCC or FAP
- Use of propofol as anesthesia during endoscopy, unless specifically required and approved by the program's MAB in cases where the client cannot be sedated with standard moderate sedation

Claim Forms

Original HCFA 1500 and UB 92 forms must be used to submit claims to PCS. The following information is needed to process claims:

- Participant's complete name and address
- Participant's birth date
- Dates of service
- CPT codes for services provided
- ICD-9 (Diagnostic) code
- Charges for services
- Facility name, address and Tax ID number
- If insurance is involved, complete:
    - → For the HCFA 1500 – Boxes 28 (Total Charge), 29 (Amount Paid) and 30 (Balance Due)
    - → For the UB 92 – Boxes 54 (Prior Payments) and 55 (Estimated Amount Due)

IGS is the payer of last resort. If a participant has insurance, claims must be submitted first to their insurance company and an explanation of benefits (EOB) obtained. **Do not submit the EOB to Provider Claim Systems.** If reimbursement is received from an insurance company, it is the responsibility of the health care provider's billing agency to enter on the claim form the amount of

reimbursement received. The program will reimburse, including co-pay and deductibles, up to the rate on the current reimbursement schedule.

Claims Submission

1) Provider facilities can submit claims to Provider Claim Systems at the address below:

Provider Claim Systems
PO Box 1608
Mason City, IA 50402-1608

Allow 3 weeks for reimbursement from the time PCS receives the claim for reimbursement. PCS will send a remittance notice with the reimbursement check to identify claims being paid to the provider.

NOTE: Any participant who is not enrolled into the PCS data base (in addition to our IGS data system), will not be recognized as an eligible participant by PCS; therefore, any claims submitted for them to PCS will be denied. This would include FIT processing and endoscopy-related claims. Also, any provider group who has not completed a Provider/Cooperative Agreement with IDPH/IGS will be denied reimbursement by PCS for IGS-related services. Questions about claims should be directed to Lori Wink with PCS at (800) 547-6789 ext. 34.

OTHER INFORMATION

PCS Provider Database

IGS maintains a database of participating IGS health care providers. The database is used to determine provider eligibility.

- Participating provider groups must notify IDPH/IGS of the following:
  - → Changes in professional staff.
  - → Change of gastrointestinal facility to which you refer patients.
  - → Change of location (the location at which a participating provider sees patients must have a newly signed *Provider/Cooperative Agreement* to allow the provider to participate in IGS).
  - → Change in professional status, licensing, certification, tax ID number, etc.

PCS Claims Database

All new participants are entered into the PCS claims database at the same time they are entered into the IGS data system. This data base is used to monitor monthly claims and it allows PCS to determine which individuals are eligible for reimbursement.

QUALITY ASSURANCE & IMPROVEMENT

Quality assurance and improvement are integral components of the Iowa Get Screened program and contribute to program success. As part of the vision, *to reduce morbidity and mortality from colorectal cancer*, high-quality, timely participant services are essential.

Program requirements and monitoring activities include:

- Standards for adequacy of follow-up: data reports track appropriate and timely short-term, diagnostic and rescreening services.
- Case Management services: local program staff evaluates needs, implements plans and refers clients who need diagnostic services and/or are diagnosed with cancer.

- Colorectal Cancer Data Elements (CCDEs): CCDE's are reported to the CDC semi-annually by the Iowa Department of Public Health.
- Evaluation: reports are completed routinely and on an as needed basis to assess whether or not IGS is meeting CDC goals. IGS Staff work closely with the program evaluator on screening and all projects.
- Adherence to CDC policies and guidelines.

Proposed Indicator Type, Number and Description	CDC Benchmark		
Screening Priority Population	1	Percent of new clients screened who are at average risk for CRC	≥75%
	2	Percent of average risk new clients screened who are aged 50 years and older	≥95%
Completeness of Clinical Follow-up	3	Percent of abnormal test results with diagnostic follow-up completed	≥90%
	4	Percent of diagnosed cancers with treatment initiated	≥90%
Timeliness of Clinical Follow-up	5	Percent of positive tests (FOBT/FIT, sigmoidoscopy, or DCBE) followed-up with colonoscopy within 90 days (This measure will not apply to all programs)	≥80%
	6	Percent of cancers diagnosed with treatment initiated within 60 days	≥80%

CONTACT INFORMATION

Changes in provider address, staff names or status (e.g. staff that join or leave a facility), billing services and other pertinent information must be submitted to the Iowa Get Screened: Colorectal Cancer Program.

Iowa Get Screened: Colorectal Cancer Program
Iowa Department of Public Health
Lucas State Office Building, 4th Floor
321 E. 12th Street
Des Moines, IA 50319-0075
(P) 515-281-4779

Changes to the Iowa Get Screened program may be made without advance notice, based on guidance from the Centers for Disease Control and Prevention (CDC) or the program's Medical Advisory Board. Local program coordinators, health care providers and other appropriate partners will receive notification of program updates.

APPENDICIES

CANCER IN IOWA

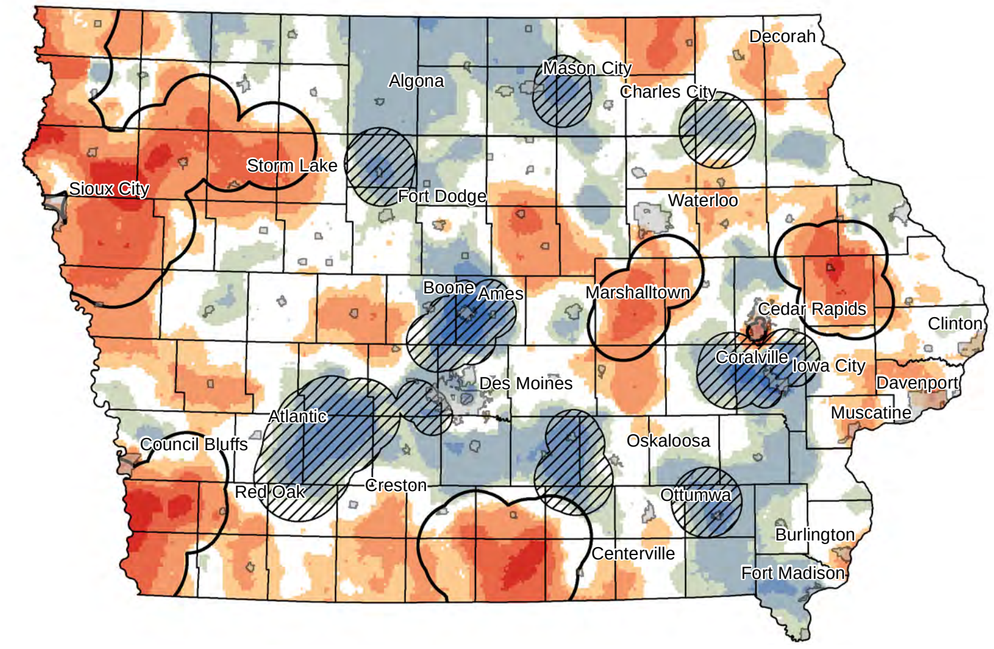
Colorectal Cancer Incidence

Incidence is a measure of the number of colorectal cancer cases diagnosed during an interval of time. Cases are defined as all persons over the age of 50 who were newly diagnosed with colorectal cancer before December 31, 2009. On this map, the population at-risk for colorectal cancer is all persons over the age of 50 in Iowa.

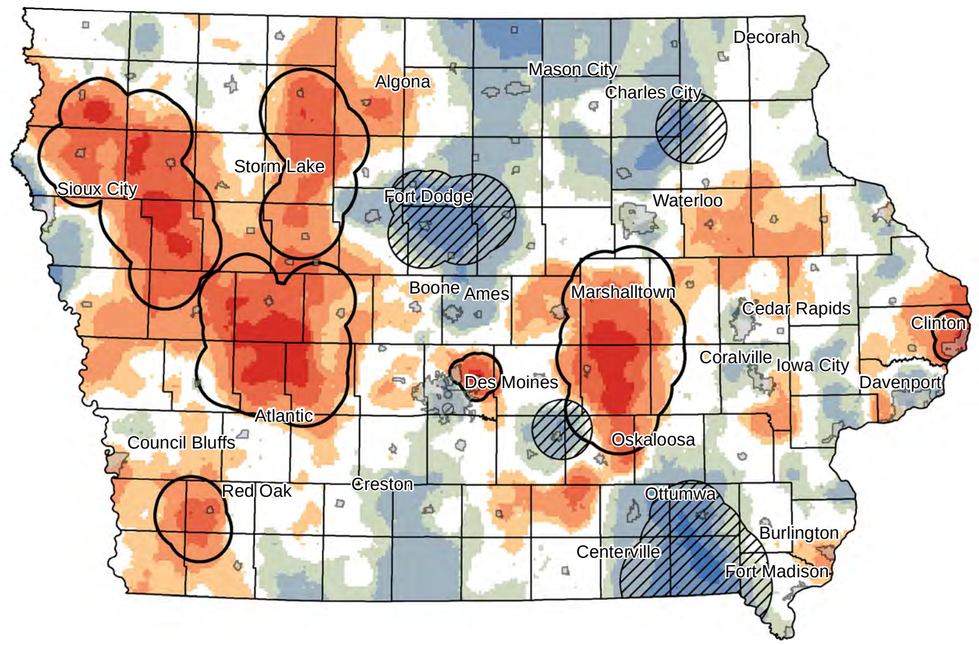
The mapped values for colorectal cancer incidence are odds ratios which compare local colorectal cancer incidence to the entire state. Values greater than 1 indicate that colorectal cancer incidence is higher than the state-level and are symbolized as red. Values less than 1 indicate that colorectal cancer incidence is lower than the state-level and are symbolized as blue. The clusters identify areas within the state that have an odds of incidence significantly higher than the odds at the state-level.

The persistence maps show areas that were persistently higher or lower than the state for all three time periods.

1998 to 2001



2002 to 2005

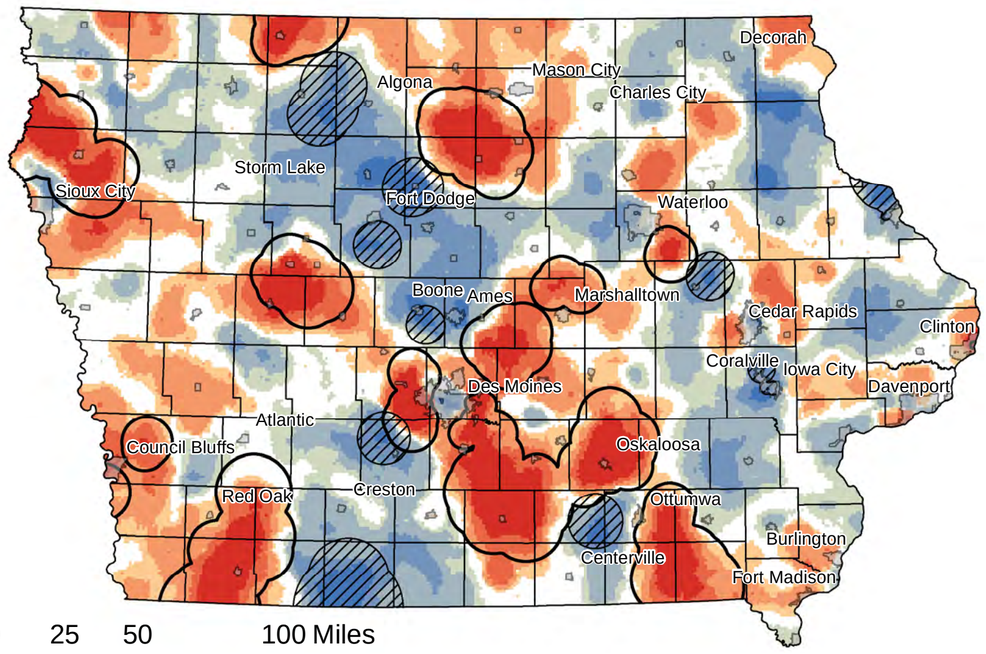


Incidence

(age and gender adjusted)

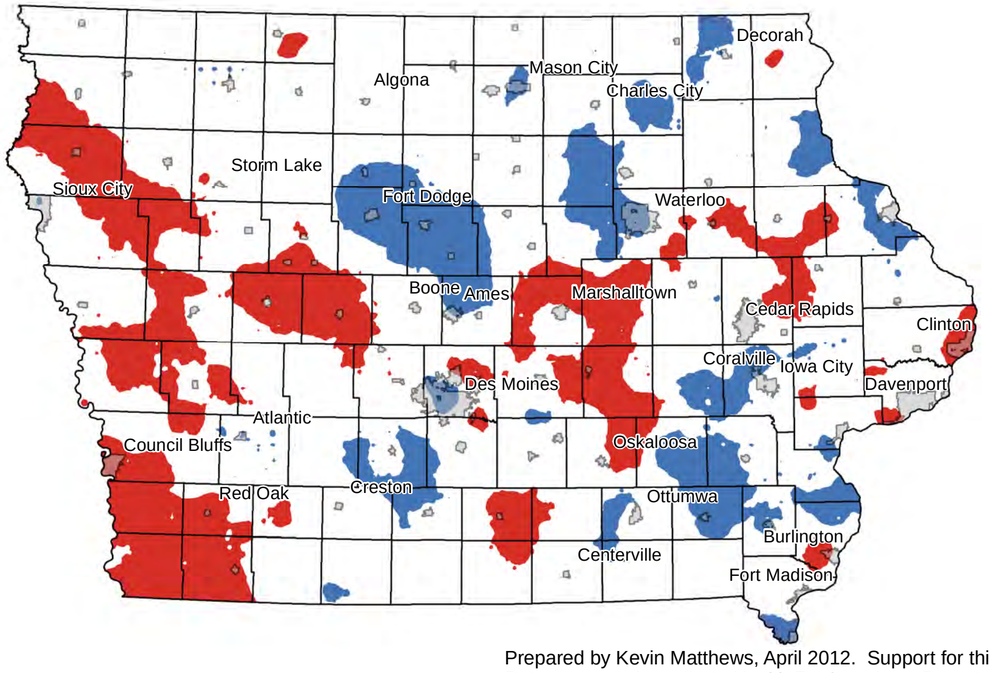
- 0.549 - 0.7
- 0.701 - 0.8
- 0.801 - 0.9
- 0.901 - 0.95
- 0.951 - 1.05
- 1.051 - 1.1
- 1.101 - 1.2
- 1.201 - 1.3
- 1.301 - 1.4
- High Incidence Clusters
- Low Incidence Clusters

2006 to 2009



0 25 50 100 Miles

Persistence 1998 to 2009



- Persistently Low Incidence
- Persistently High Incidence

Prepared by Kevin Matthews, April 2012. Support for this map provided by NIH RC4 grant: 1RC4CA15343
Data sources: Iowa State Health Registry, Iowa Department of Public Health, US Census 2000

CANCER IN IOWA

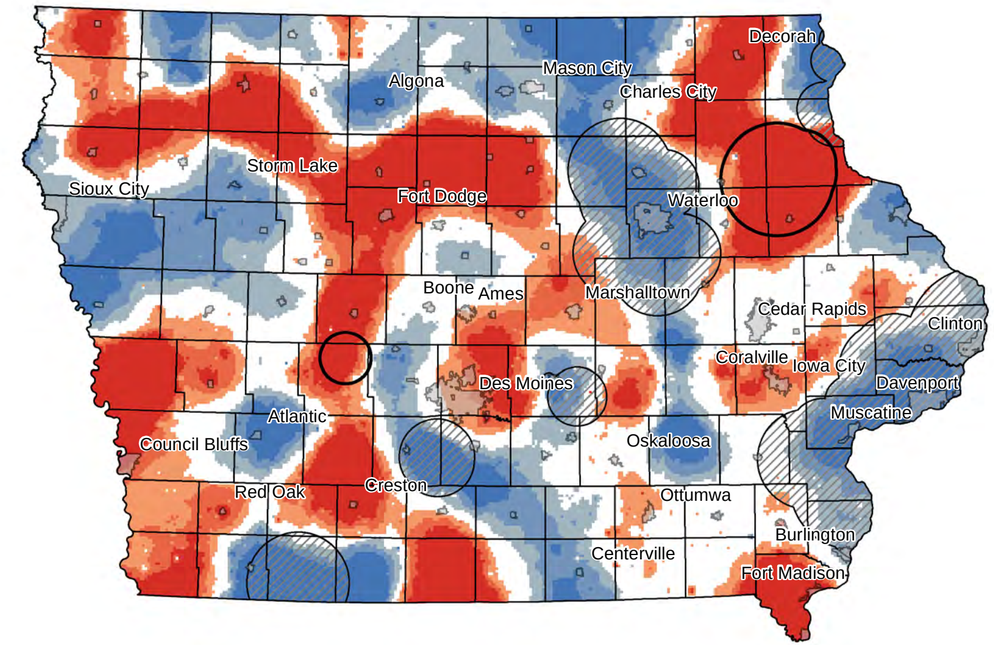
Colorectal Cancer Late-Stage Incidence

Late-stage colorectal cancer incidence is a measure of the number of invasive colorectal cancer cases diagnosed during an interval of time. Cases are defined as all persons 50 and older who were newly diagnosed with Stage III - VII colorectal cancer before December 31, 2009.

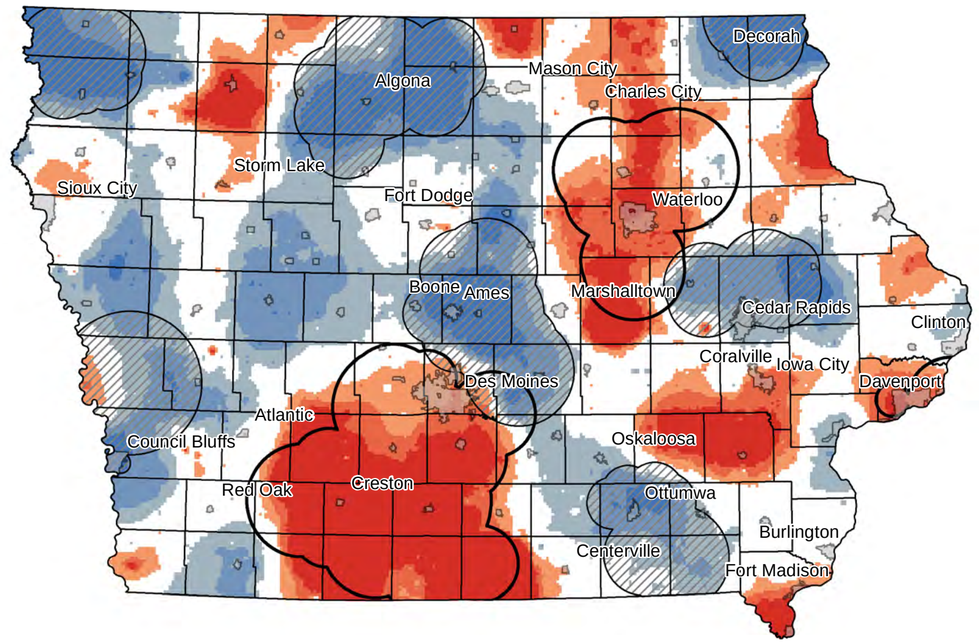
The mapped values for late-stage incidence are odds ratios comparing local late-stage colorectal cancer incidence to the entire state. Values greater than 1 indicate that late-stage colorectal cancer incidence is higher than the state-level and are symbolized as red. Values less than 1 indicate that late-stage colorectal cancer incidence is lower than the state level and are symbolized as blue. The clusters identify areas within the state that have an odds of late-stage incidence significantly higher than the odds at the state-level.

The persistence maps show areas that were persistently higher or lower than the state for all three time periods.

1998 to 2001



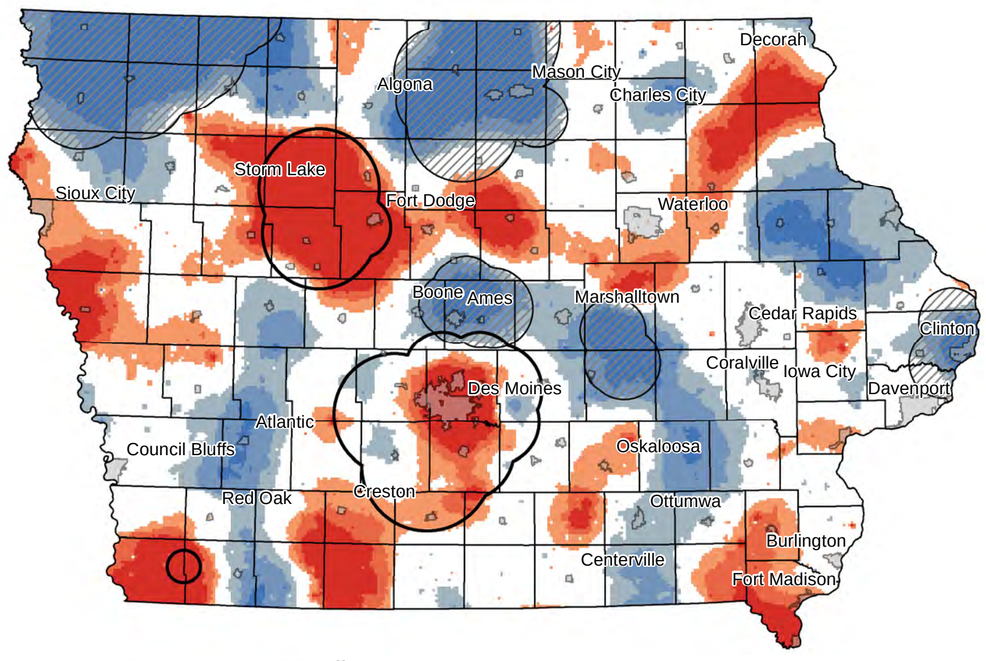
2002 to 2005



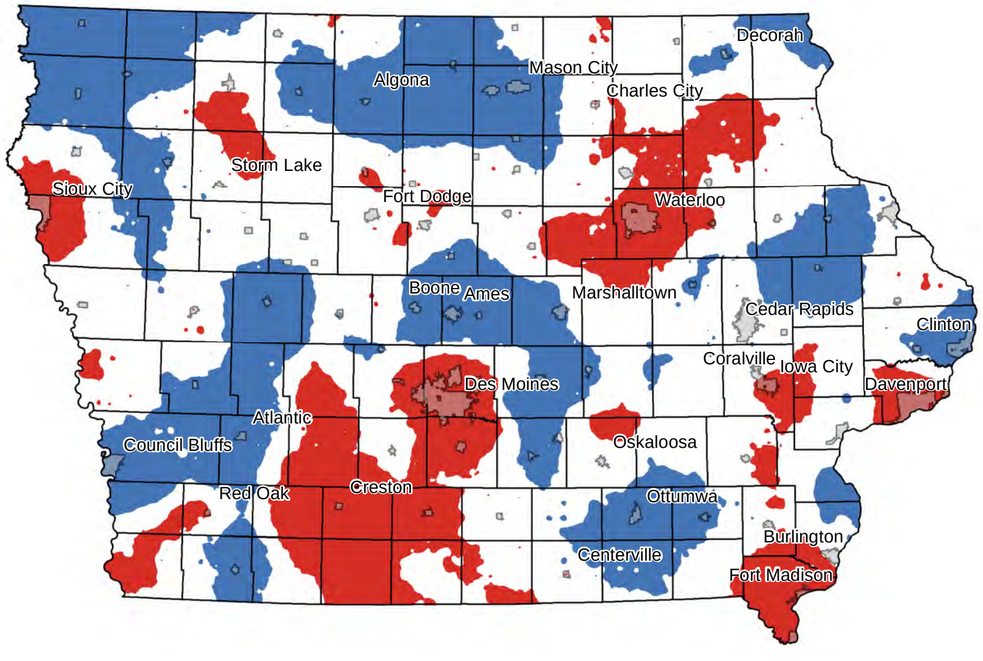
Late-Stage Incidence
(age and gender adjusted)

- 0.549 - 0.7
- 0.701 - 0.8
- 0.801 - 0.9
- 0.901 - 0.95
- 0.951 - 1.05
- 1.051 - 1.1
- 1.101 - 1.2
- 1.201 - 1.3
- 1.301 - 1.4
- High Late-Stage Incidence
- Low Late-Stage Incidence

2006 to 2009



Persistence 1998 to 2009



- Low Late-Stage Persistence
- High Late-Stage Persistence

0 25 50 100 Miles

Prepared by Kevin Matthews, April 2012. Support for this map provided by NIH RC4 grant: 1RC4CA15343
Data sources: Iowa State Health Registry, Iowa Department of Public Health, US Census 2000

CANCER IN IOWA

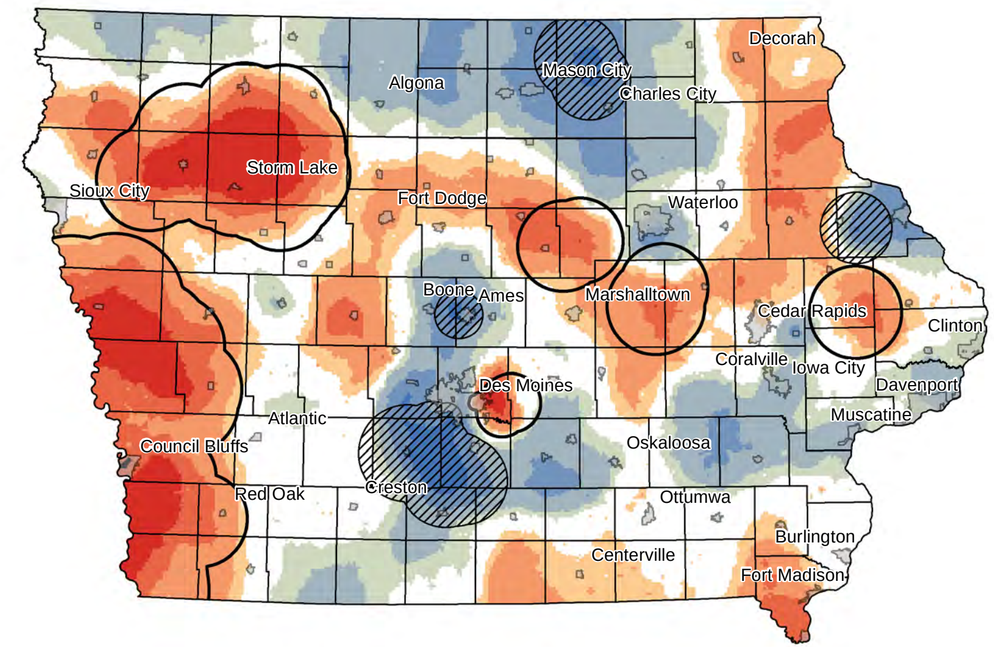
Colorectal Cancer Mortality

Colorectal cancer mortality is a measure of the number of colorectal cancer deaths during an interval of time. The population at-risk for colorectal cancer death is all persons over the age of 50 in Iowa. Cases are defined as all persons over the age of 50 who were newly diagnosed with colorectal cancer before December 31, 2009. Deaths are defined as any person over the age of 50 whose primary cause of death was identified as colorectal cancer between 1998 and 2009.

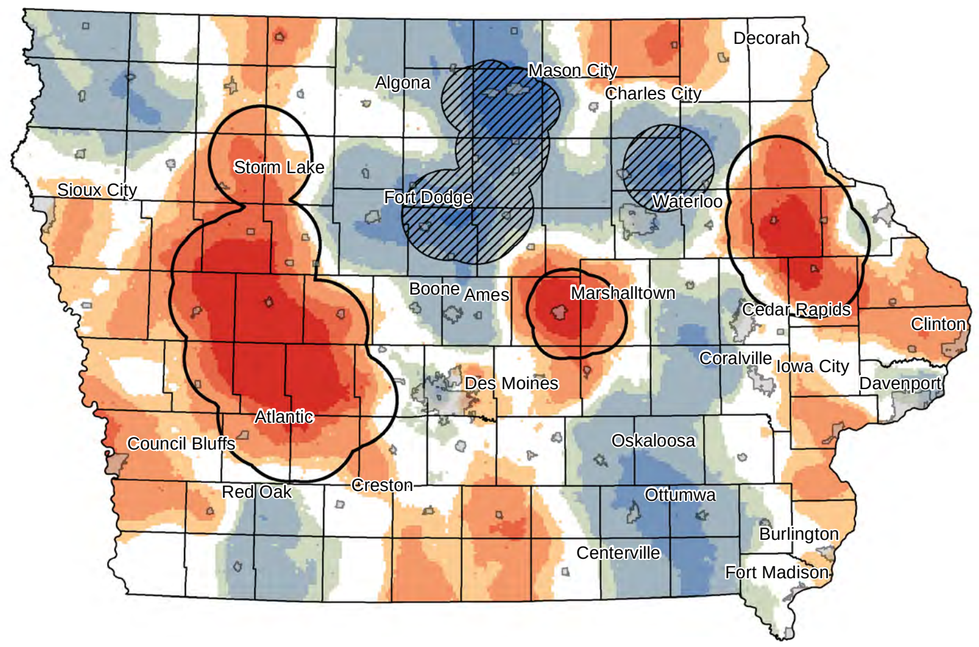
The mapped value for mortality are odds ratios comparing local colorectal cancer mortality to the entire state. Values greater than 1 indicate that colorectal cancer mortality is higher than the state-level and are symbolized as red. Values less than 1 indicate that colorectal cancer mortality is lower than the state-level and are symbolized as blue. The clusters identify areas within the state that have an odds of mortality significantly higher than the odds at the state-level.

The persistence maps show areas that were persistently higher or lower than the state for all three time periods.

1998 to 2001



2002 to 2005

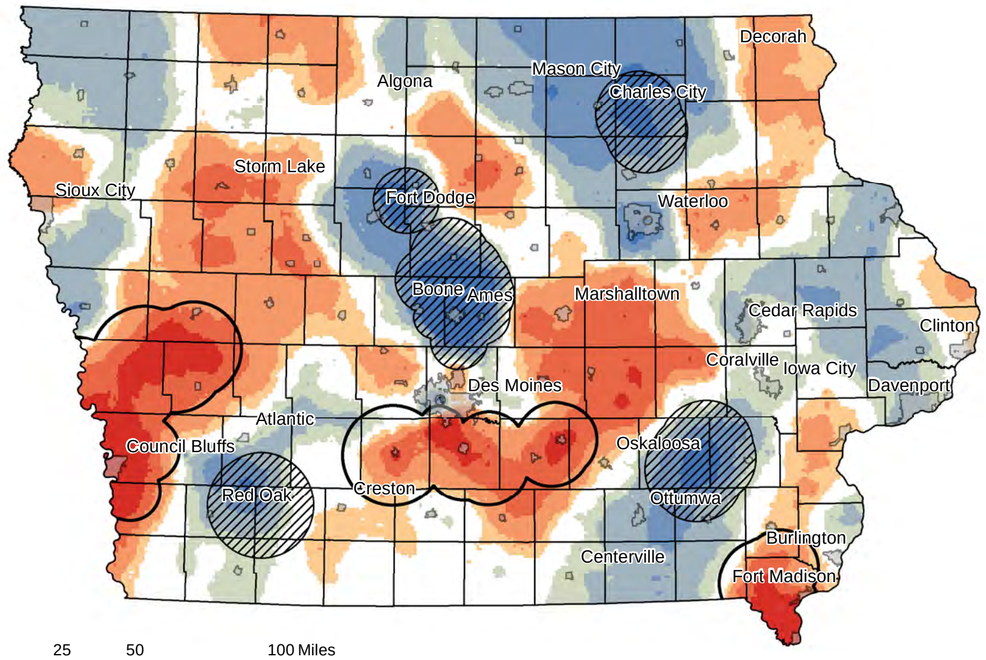


Mortality

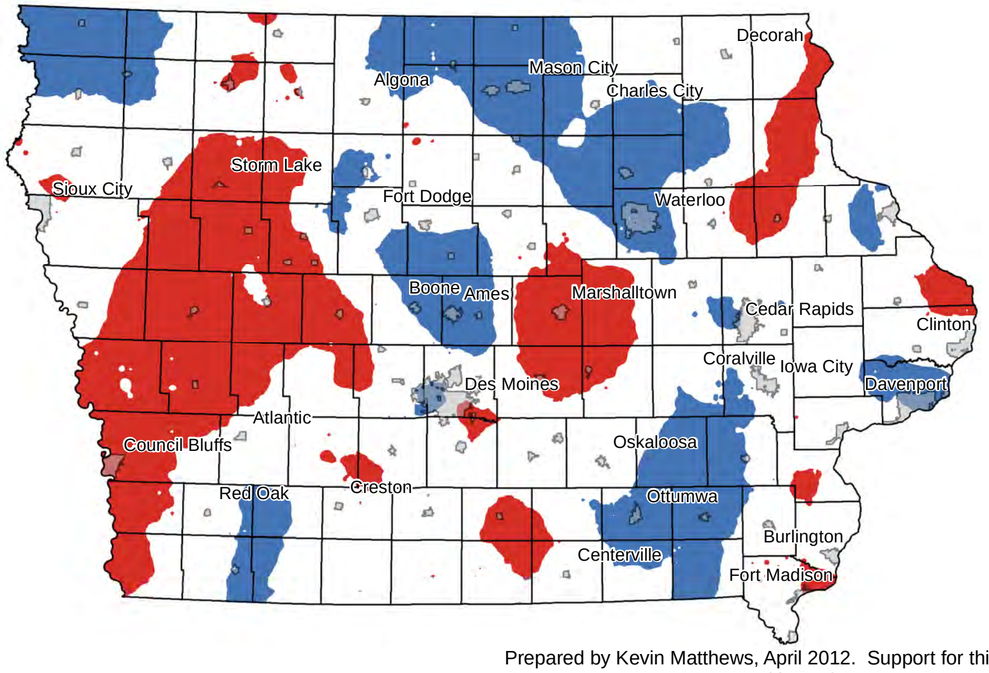
(age and gender adjusted)

- 0.549 - 0.7
- 0.701 - 0.8
- 0.801 - 0.9
- 0.901 - 0.95
- 0.951 - 1.05
- 1.051 - 1.1
- 1.101 - 1.2
- 1.201 - 1.3
- 1.301 - 1.4
- High Mortality Clusters
- Low Mortality Clusters

2006 to 2009



Persistence 1998 to 2009



- Persistently Low Mortality
- Persistently High Mortality

0 25 50 100 Miles

Prepared by Kevin Matthews, April 2012. Support for this map provided by NIH RC4 grant: 1RC4CA15343
Data sources: Iowa State Health Registry, Iowa Department of Public Health, US Census 2000

Appendix B

2015 Income Guidelines

Persons in Household	Yearly Income	Monthly Income
1	$ 29,425	$ 2,452
2	39,825	3,319
3	50,225	4,185
4	60,625	5,052
5	71,025	5,919
6	81,425	6,785
7	91,825	7,652
8	102,225	8,519
For families/households with more than 8 persons, add:	$ 10,400 for each person	$ 867 for each person

Iowa Get Screened: Colorectal Cancer Program Income Guidelines are updated annually. For updates, contact:

Iowa Get Screened: Colorectal Cancer Program
Iowa Department of Public Health
Lucas State Office Building
321 E. 12th Street
Des Moines, IA 50319-0075
Phone: (515) 281-4779

Appendix C

Iowa Get Screened: Colorectal Cancer Program

Informed Consent and Release of Medical Information

Program #: _____ **Client #:** _____ **Date of Birth:** _____/_____/_____

Name: _____ **Home Phone:** (_____) _____-_____
PLEASE PRINT

Cell Phone: (_____) _____-_____

Address: _____
PLEASE PRINT ***STREET*** ***CITY*** ***STATE*** ***ZIP***

*** Read and sign this consent and release to show that you know what it means and agree to it.**
*** Read about program services on the back of this consent.**
*** Sign this consent to be part of the *Iowa Get Screened* Program.**

1) I want to be a part of the *Iowa Get Screened* Colorectal Cancer Program. This program screens men and women for colorectal cancer. To be a part of the program, I know I must be between the ages of 50-64, have no colorectal cancer symptoms, earn less than the set income guidelines and be uninsured or underinsured.
2) Being a part of this program is my choice. I can tell the *Iowa Get Screened* staff if I no longer want to be part of the program.

Please contact your local program staff <u>right away</u>
if you have any questions.
Staff name: _____ **Phone #:** _____

3) I have talked with the program staff about how I will pay for tests or services not covered by *Iowa Get Screened*.
4) I accept responsibility for following advice my health care provider may give me.
5) I give permission for my health care provider, laboratory, clinic, radiology unit and/or hospital to provide the *Iowa Get Screened* Program results of my colorectal screening exams, follow-up exams and treatment. This includes results for program services provided within one year of the date below.
6) *Iowa Get Screened* will use my name, address, and other personal information to remind me of screening or follow-up exams, and to help me find treatment.
7) *Iowa Get Screened* and the Centers for Disease Control and Prevention (CDC) may approve studies to help researchers learn about colorectal health. My name will not be used. My information will be combined with other participant's information before it is shared.
8) Please contact the person who is listed below, who does not live with me, if you cannot reach me with important information about my health.

Name: _____ Phone: (_____) _____-_____ Relationship: _____
PLEASE PRINT

Address: _____
STREET *CITY* *STATE* *ZIP*

9) I release this program and its employees and agents from any claims, demands, and actions related to my participation in *Iowa Get Screened*. This includes any claims related to a failure to detect or diagnose cancer, failure of treatment, or any acts or omissions related to diagnosis or treatment while I am part of the program.

_____ _____ _____ _____
Client Signature **Date** **Provider Signature** **Date**

HIPAA allows for disclosure of protected health information to public health authorities for public health activities.

Appendix C

Iowa Get Screened: Colorectal Cancer Program

Program Services

Iowa Get Screened can pay for:	
If I am an eligible participant between the ages of 50-64	Screening Tests and Procedures • Fecal Immunochemical Tests annually • Colonoscopy every 10 years, from last screen • Biopsy/polypectomy during a colonoscopy • Bowel preparation • Moderate sedation for colonoscopy • Office visit related to above tests Diagnostic follow-up services as recommended • Office visit related to screening and diagnostic tests • Total colon exam with either colonoscopy (preferred) or DCBE if medically prescribed by doctor • Biopsy/polypectomy during colonoscopy • Moderate sedation for colonoscopy • Bowel preparation • Pathology fees

Iowa Get Screened does not pay for:	
If I am an eligible participant between the ages of 50-64	• Screening tests requested at intervals sooner than are recommended by for national guidelines • CT Colonography (or virtual colonoscopy) as a primary screening test. • Computed Tomography Scans (CTs or CAT scans) requested for staging or other purposes. • Surgery or surgical staging, unless specifically required and approved by the program's MAB to provide a histological diagnosis of cancer. • Any treatment related to the diagnosis of colorectal cancer. • Any care or services for complications that result from screening or diagnostic tests provided by the program. • Evaluation of symptoms for clients who present for CRC screening but are found to have gastrointestinal symptoms. • Diagnostic services for clients who had an initial positive screening test performed outside of the program. • Management of medical conditions, including Inflammatory Bowel Disease (e.g., surveillance colonoscopies and medical therapy). • Genetic testing for clients who present with a history suggestive of a HNPCC or FAP. • Use of propofol as anesthesia during endoscopy, unless specifically required and approved by the program's MAB in cases where the client cannot be sedated with standard moderate sedation.

Iowa Get Screened: Colorectal Cancer Program

Allowable Procedures and Relevant 2013 CPT, HCPCS, and APC Codes
Based on Medicare Part B Rates

CPT® Modifier	Procedure Code Description	Hospital Outpatient Reimbursement Rate	Professional Reimbursement Rate-26	Technical Reimbursement Rate-TC
	Fecal Immunochemical Test (FIT)	$8.94		
82274*	Blood, occult, by fecal hemoglobin, determined by immunoassay, qualitative, feces, 1-3 simultaneous determinations.	$21.86 $27.00 total **Endnote-1**		
	Note: (Codes 82271 (other sources) and 82272 (single specimen) are not included as they do not adhere to guideline-recommended screening).			
CPT® Modifier	**Procedure Code Description**	**Hospital Outpatient Reimbursement Rate**	**Professional Reimbursement Rate-26**	**Technical Reimbursement Rate-TC**
Colon Prep Kit (cprep)	Colon Prep Kit, Prescription medicine or prescribed over the counter prep. Shall cover the cost of the prep and any postage to get prep to IGS participant up to $68.97 for all expenses occurred. Stamps to mail prep may be obtained at from the state program manager at 1-515-281-4909 if needed.	**IGS will pay up to** $68.97		
G0121	Screening colonoscopy on average risk individual.	$565.08	$201.09	
G0105	Screening Colonoscopy on high risk individual.	$565.08	$201.09	
45378	Colonoscopy, flexible, proximal to splenic flexure; diagnostic, with or without collection specimen(s) by brushing or washing, with or without colon decomposition (separate procedure).	$638.56	$201.09	
45380	Colonoscopy, flexible, proximal, to splenic flexure; with biopsy, single or multiple.	$638.56	$240.49	
45381	Colonoscopy, flexible, proximal to splenic flexure; with directed submucosal injection(s), any substance.	$638.56	$228.38	
45382	Colonoscopy, flexible, proximal to splenic flexure; with control of bleeding (e.g., injection, bipolar cautery, unipolar cautery, laser, heater probe, stapler,	$638.56	$306.17	

	plasma coagulator).			
45383	Colonoscopy, flexible, proximal to splenic flexure; with ablation of tumor(s), polyp(s), or other lesion(s) not amenable to removal by hot biopsy forceps, bipolar cautery or snare technique.	$638.56	$311.87	
45384	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by hot biopsy forceps or bipolar cautery.	$638.56	$250.87	
45385	Colonoscopy, flexible, proximal to splenic flexure; with removal of tumor(s), polyp(s), or other lesion(s) by snare technique.	$638.56	$285.38	
	Note: When submitting a claim for the interrupted colonoscopy, professional providers are to suffix the colonoscopy code with a modifier of "-53 to indicate that the procedure was interrupted. SOME providers will use –modifier 52. This is an often confusing issue and depends upon why the procedure was interrupted.			
CPT® Modifier	**Procedure Code Description**	**Global Reimbursement Rate**	**Professional Reimbursement Rate-26**	**Technical Reimbursement Rate-TC**
74270	Radiologic examination, colon; barium enema, with or without KUB	$140.44	$31.64	$108.80
		Endnote-2		
74280	Radiologic examination, colon; air contrast with specific high density barium, with or without glucagon.	$154.12	$45.32	$108.80
		Endnote-2		
CPT® Modifier	**Procedure Code Description**	**Global Reimbursement Rate**	**Professional Reimbursement Rate-26**	**Technical Reimbursement Rate-TC**

88300	Surgical pathology, gross examination only (surgical specimen)	$12.99	$4.08	$8.91
88302	Surgical pathology, gross microscopic examination (review level II)	$27.67	$6.39	$21.28
88304	Surgical pathology, gross microscopic examination (review level III)	$40.09	$10.66	$29.43
88305	Surgical pathology, gross microscopic examination, colon, colorectal polyp biopsy (review level IV)	$64.76	$35.33	$29.43
88307	Surgical pathology, gross examination, colon, segmental resection other than for tumor (review level V)	$269.14	$78.26	$190.88
88309	Surgical pathology, gross microscopic examination, colon, segmental resection other than for tumor (review level V)	$407.81	$138.15	$269.66
88342	Pathology: Immunocytochemistry, each antibody	$104.99	$40.25	$64.74
CPT® Modifier	**Procedure Code Description**	**Global Reimbursement Rate**		
99201**	New Patient; history, exam straightforward decision-making; 10 minutes	$40.19 – Non Facility		
99202	New Patient; expanded history, exam, straightforward decision-making; 20 minutes	$68.64 – Non Facility		
99203	New Patient, detailed history, exam, straightforward decision-making; 30 minutes	$99.37 – Non Facility		
99211**	Established Patient; evaluation and management, may not require presence of physician; 5 minutes	$18.65 – Non Facility		
99212	Established Patient, history, exam, straightforward decision-making; 10 minutes	$40.19 – Non Facility		
99213	Established Patient; expanded history, exam, straightforward decision-making; 15 minutes	$67.28 – Non Facility		
99241**	Problem focused history & examination with straightforward medical decision. **Paid at the 99201 Rate.	$40.19		
CPT®	**Procedure Code Description**	**Global**		

Modifier		Reimbursement Rate		
00810	Anesthesia for lower intestinal endoscopic procedures, endoscope introduced distal to duodenum	$20.50/unit **End Note-3**		
00840	Anesthesia for intraperitoneal procedures in lower abdomen including laparoscopy; not otherwise specified	$20.50/unit		
	Anesthesia codes – CDC will only reimburse for standard anesthesia related to the endoscopic procedure			
CPT® Modifier	**Procedure Code Description**	**Global Reimbursement Rate**		
93000	Electrocardiogram, routine ECG with at least 12 leads; with interpretation and report	$16.66		
93005	Electrocardiogram, routine ECG with at least 12 leads; tracing only, without interpretation and report	$8.91		
93010	Electrocardiogram, routine ECG with at least 12 leads; tracing only, interpretation and report only	$7.75		
93040	Rhythm ECG, one to three leads; with interpretation and report	$12.05		
93041	Rhythm ECG, one to three leads; tracing only, without interpretation and report	$5.29		
93042	Rhythm ECG, one to three leads; interpretation and report only	$6.77		
CPT® Modifier	**Procedure Code Description**	**Global Reimbursement Rate**		
80048	Basic metabolic panel (calcium total). This panel must include the following: calcium, total (82310), carbon dioxide (82374), creatinine (82565), glucose (82947), potassium (84132), sodium (84295)	$11.63		
85025	Blood count; complete (CBC), automated (Hgb, Hct,			

	RBC, WBC and platelet count) and automated differential WBC count	$10.69		
80053	Comprehensive Metabolic panel. This panel must include the following: albumin (82041; bilirubin, total (82247); calcium (82310); carbon dioxide (bicarbonate) (82374); chloride (82435); creatinine (82565); glucose (82947); phosphatase, alkaline (84075); potassium (84132); protein, total (84155); sodium (84295); transferase, alanine amino (84460); transferase, aspartate amino (84450; urea nitrogen (84520)	$14.53		
85027	Blood Count; complete (CBC), automated (Hgb, Hct, RBC, WBC and platelet count)	$8.89		
85610	Prothrombin time	$4.80		
82962	Glucose Blood Test	$2.48		
85730	Thromboplastin time, partial (PTT); plasma or whole blood	$7.17		

Modifier	**Procedure Code Description**
-53	A discontinued procedure due to extenuating circumstances or those that threatens the well being of the patient. Not to be used to report elective cancellation.
-73	Discontinued procedure prior to anesthesia
-74	Discontinued procedure after anesthesia
-26	Professional Component
-TC	Technical Component
-QW	Waived test under CLIA*

Code/Modifier	**Procedure Code Description**
Any	Treatment of colorectal cancer or any other diagnosed as a result of participation in the program.
Any	Treatment of medical conditions diagnosed as a result of participation in the program or that existed prior to entry into the program.
Any	Care or services for complications that result from screening or diagnostic tests provided by the program.
Any	Evaluation of symptoms for clients who present for CRC screening but are found to have gastrointestinal symptoms.
Any	Diagnostic services for clients who had an initial positive screening test performed outside the program.
Any	CT Colonography (or virtual colonoscopy) as a primary screening test.

Any	Computed Tomography Scans (CT's or CAT scans) requested for staging or other purposes.
Any	Genetic testing for clients who present with a history suggestive of a HNPCC or FAP
Any	Use of propofol as anesthesia during endoscopy
End note- 1	Codes 82271 (other sources) and 82272 (single specimen) are not included as they do not adhere to guideline-recommended screening.
End note- 2	G0106 (colorectal cancer screening; barium enema; as an alternative to G0104; screening sigmoidoscopy), G0120 (colorectal cancer screening; barium enema; as an alternative to G0105; screening colonoscopy), and G0122 (colorectal cancer screening; barium enema) are not included as barium enema is no longer recommended by USPSTF as a colorectal cancer screening test. Double contrast barium enema may still be used as a diagnostic test to evaluate an abnormal FIT or gFOBT (Note: Colonoscopy is the preferred test in this circumstance).
End note-3	If the client fails standard moderate sedation, anesthesia may be used to complete the endoscopic procedure. Documentation should be provided to support the use of anesthesia on a case-by-case basis.

* The Current Procedural Terminology (CPT) codes for this test must have the modifier QW to be recognized as a waived test. These are tests approved by the Food and Drug Administration as a waived test under the Clinical Laboratory Improvement Amendments of 1988 (CLIA).

**This amount will be paid to both the provider and the facility.

This form is to be used to determine patient eligibility prior to enrollment

Iowa Get Screened (IGS): Colorectal Cancer Program
Patient Eligibility and Screening Determination

Initial Screening Questions

- Are you 50 – 64 years of age?
- Do you have a household income of up to 250% FPG (use program income guidelines to make determination)?
- Have you been experiencing any of these symptoms? (If "yes" to any of the following, then the client is ineligible for IGS services and will need to be referred out of the program for the appropriate medical care or evaluation. Once their symptom(s) has been cleared by a physician, and if they meet all other eligibility requirements, they can be enrolled into the program).
  - Rectal bleeding, bloody diarrhea, or very dark blood in the stool within the past 6 months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving IGS screening services).
  - Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated).
  - Persistent/ongoing abdominal pain.
  - Recurring symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation).
  - Significant unintentional weight loss of 10% or more of starting body weight *(Example: If a person weighs 150 pounds, 10% of his/her body weight is 15 pounds).*

2015 Income Guidelines

Persons in Household	Yearly Income	Monthly Income
1	$ 29,425	$ 2,452
2	39,825	3,319
3	50,225	4,185
4	60,625	5,052
5	71,025	5,919
6	81,425	6,785
7	91,825	7,652
8	102,225	8,519
For families/households with more than 8 persons, add:	$ 10,400 for each person	$ 867 for each person

IGS Guidelines for Screening in Individuals at Average, Increased or High Risk

		Average Risk	Increased Risk	High Risk
Personal History of Precancerous Polyps or Colorectal Cancer	Has current CRC symptoms or a history of inflammatory bowel disease (ulcerative colitis or Crohn's) or of genetic syndromes such as HNPCC or FAP			Ineligible
	FIT or FOBT performed prior to one full calendar year			Ineligible
	Positive FIT or FOBT in the last 5 years (outside the program that didn't receive follow-up)			Ineligible
	Colonoscopy performed in the last 10 years (unless different timeframe recommended by physician)			Ineligible
	Previously diagnosed with CRC or precancerous polyps and **hasn't** completed treatment			Ineligible
	No personal history of CRC or precancerous polyps	FIT		
	Previously diagnosed with CRC or precancerous polyps and **has** completed treatment		Colonoscopy (surveillance)	
Family History of Precancerous Polyps	**0** first degree relatives with precancerous polyps	FIT		
	1 or more first degree relatives of **any age** with precancerous polyps		Colonoscopy (screening)	
Family History of Colorectal Cancer	0 first degree relatives diagnosed with CRC	FIT		
	1 or more first degree relatives, all older than age 60, diagnosed with CRC		Colonoscopy (screening)	
	No more than 1 first degree relative, younger than age 60, diagnosed with colorectal cancer		Colonoscopy (screening)	
	2 or more 2nd degree relatives older than age 60 diagnosed with CRC		Colonoscopy (screening)	
	2 or more first degree relatives, younger than age 60, diagnosed with CRC			Ineligible

This form is to be used to determine patient eligibility prior to enrollment

Iowa Get Screened (IGS): Colorectal Cancer Program
Patient Eligibility and Screening Determination

Initial Screening Questions

- Are you 50 – 64 years of age?
- Do you have a household income of up to 250% FPG (use program income guidelines to make determination)?
- Have you been experiencing any of these symptoms? (If "yes" to any of the following, then the client is ineligible for IGS services and will need to be referred out of the program for the appropriate medical care or evaluation. Once their symptom(s) has been cleared by a physician, and if they meet all other eligibility requirements, they can be enrolled into the program).
  - Rectal bleeding, bloody diarrhea, or very dark blood in the stool within the past 6 months (bleeding that is known or suspected to be due to hemorrhoids after clinical evaluation would not prevent a client from receiving IGS screening services).
  - Prolonged change in bowel habits (e.g., diarrhea or constipation for more than two weeks that has not been clinically evaluated).
  - Persistent/ongoing abdominal pain.
  - Recurring symptoms of bowel obstruction (e.g., abdominal distension, nausea, vomiting, severe constipation).
  - Significant unintentional weight loss of 10% or more of starting body weight *(Example: If a person weighs 150 pounds, 10% of his/her body weight is 15 pounds).*

2015 Income Guidelines

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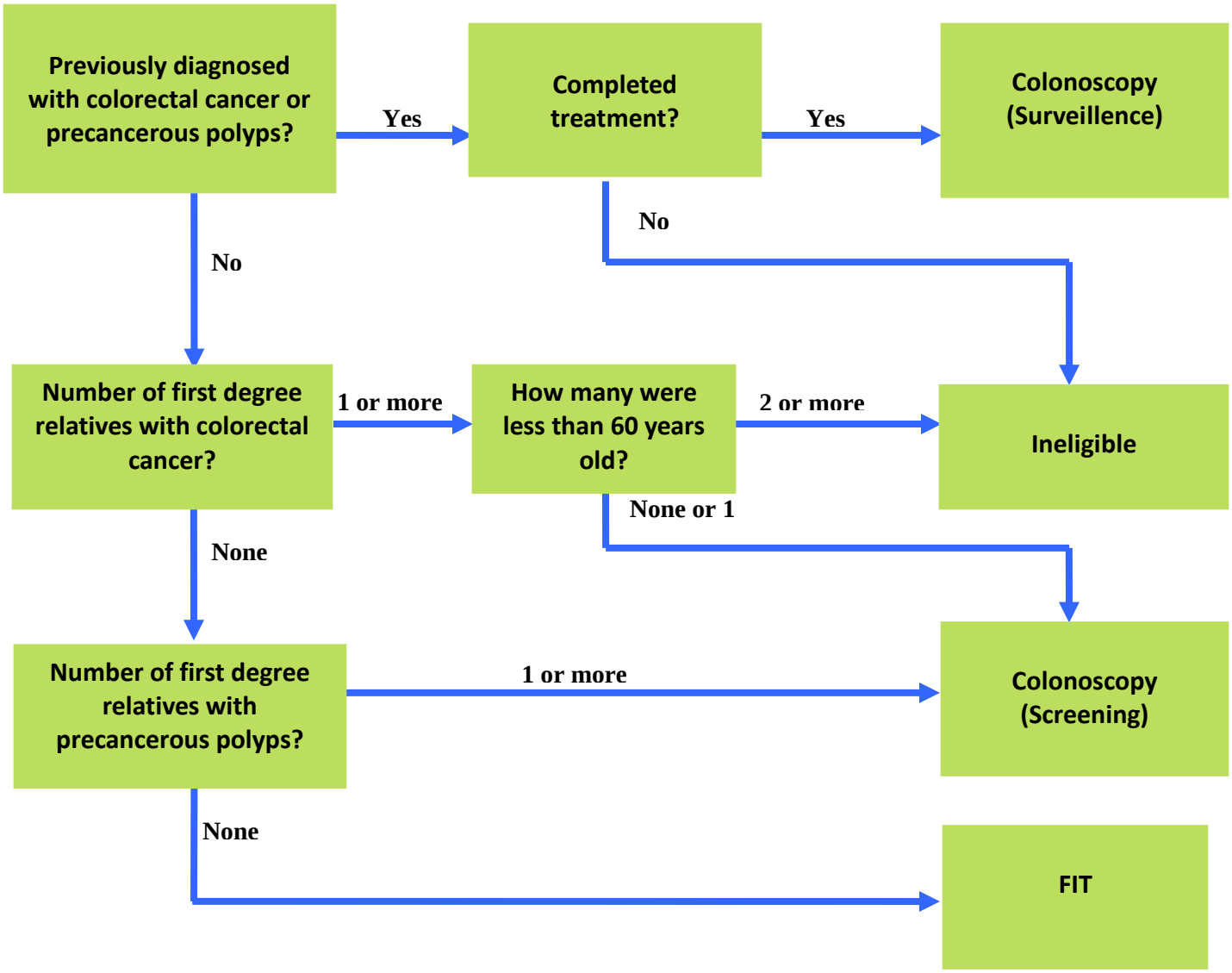
Personal History of Precancerous Polyps or Colorectal Cancer	Has current CRC symptoms or a history of inflammatory bowel disease (ulcerative colitis or Crohn's) or of genetic syndromes such as HNPCC or FAP			Ineligible
	FIT or FOBT performed prior to one full calendar year			Ineligible
	Positive FIT or FOBT in the last 5 years (outside the program that didn't receive follow-up)			Ineligible
	Colonoscopy performed in the last 10 years (unless different timeframe recommended by physician)			Ineligible
	Previously diagnosed with CRC or precancerous polyps and **hasn't** completed treatment			Ineligible
	No personal history of CRC or precancerous polyps	Colonoscopy (screening)		
	Previously diagnosed with CRC or precancerous polyps and **has** completed treatment		Colonoscopy (surveillance)	
Family History of Precancerous Polyps	**0** first degree relatives with precancerous polyps	Colonoscopy (screening)		
	1 or more first degree relatives of **any age** with precancerous polyps		Colonoscopy (screening)	
Family History of Colorectal Cancer	0 first degree relatives diagnosed with CRC	Colonoscopy (screening)		
	1 or more first degree relatives, all older than age 60, diagnosed with CRC		Colonoscopy (screening)	
	No more than 1 first degree relative, younger than age 60, diagnosed with colorectal cancer		Colonoscopy (screening)	
	2 or more 2nd degree relatives older than age 60 diagnosed with CRC		Colonoscopy (screening)	
	2 or more first degree relatives, younger than age 60, diagnosed with CRC			Ineligible

Appendix F

Screening Flow Chart



A program of the Iowa Department of Public Health made possible by a grant from the Centers for Disease Control and Prevention

Iowa Get Screened:
Colorectal Cancer Program
Iowa Department of Public Health
Division of Health Promotion and Chronic Disease Prevention
Bureau of Chronic Disease Prevention and Management
321 East 12th Street, Des Moines, Iowa 50319-0075
PHONE: 515-281-5616
FAX: 515-242-6384

STAFF DIRECTORY

	PHONE	E-MAIL

Jill Myers Geadelmann (515) 242-5616 jill.myers-geadelmann@idph.iowa.gov
Program Director; Chief, Bureau of Chronic Disease Prevention and Management
Hires and supervises staff, directs programmatic activities, assures compliance with program guidelines, and manages finances.

Jeanna Jones (515) 242-6516 jeanna.jones@idph.iowa.gov
Social Marketing/Education Coordinator
Responsible for developing program communications and promotional materials.

Jenny Hodges (515) 281-4779 jennifer.hodges@idph.iowa.gov
Screening Coordinator
Responsible for providing efficient planning and monitoring of screening and service delivery.

Victoria Brenton (515) 725-2163 victoria.brenton@idph.iowa.gov
Reporting and Coordinating Manager
Provides leadership and facilitation for reporting and budget functions.

Cancer Resource Network

Health Care Provider: Please fax the completed form to this dedicated confidential American Cancer Society number for referral: 1(866) 608-9787.

Service Referral Form

The services and information provided by the American Cancer Society could be valuable to you and your family in dealing with your cancer experience. Please complete this form and **submit to the American Cancer Society** who will contact you within 2 business days.

You will receive patient information, including information about the programs and services available through your American Cancer Society. In the mean time, if you have any questions about your cancer or the American Cancer Society's services, we are available 24 hours a day, 7 days a week.
Please call **1.800.227.2345** or visit our website at www.cancer.org.

ALL INFORMATION WILL REMAIN CONFIDENTIAL. THIS IS NOT A SOLICITIATION.

I am interested in:

☐ Cancer Information
☐ Health Insurance Assistance Program
☐ Reach to Recovery
☐ Clinical Trials Matching
☐ Look Good Feel Better
☐ Transportation
☐ I Can Cope
☐ Lodging
☐ Other: _____

***Required fields:** missing fields can slow down or prohibit our ability to provide patient services in a timely manner.

***Patient Name:** _____

***Address:** _____
Street City State Zip

***Email Address:** _____

***Daytime phone:** (_____) _____ **Okay to leave a message?** ☐ Yes ☐ No

***Gender:** ☐ Female ☐ Male ***Date of Birth:** ____/____/____

Race/Ethnicity:
☐ African American/Black
☐ Caucasian/White
☐ Pacific Islander
☐ Unknown
☐ American Indian/Alaska Native
☐ Hispanic/Latino
☐ Declined
☐ Asian
☐ Multiracial
☐ Other

Primary Language: ☐ English ☐ Spanish ☐ Other:_____

***Type of Cancer:** _____ ***Date of Diagnosis:** ____/____/____

***Type of Insurance** (Check all that apply): ☐ Private ☐ Medicare ☐ Medicaid ☐ Military Program ☐ Uninsured

***Patient/Guardian/Parent Signature:** _____ **Date:** _____

* By signing this form, you consent to the American Cancer Society's use and disclosure of the information above about you (including protected health information) in order to provide you with the American Cancer Society's information and/or services. You have the right to revoke this consent in writing. To the extent applicable, this form complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA), and a detailed description of our HIPAA policy is available for your review upon request.

***Requestor Name:** _____ ***Requestor Phone:** (_____) _____

Referral Source: **Iowa Department of Public Health** **ACS ID Number:** **1469218888**

American Cancer Society Programs

Cancer Resource Network

The American Cancer Society provides free, comprehensive patient services and programs designed to help your patients with their information, day-to-day living, and emotional support needs.
Below are some of the programs we offer.

Personal Cancer Guide
American Cancer Society Patient Navigation
Your diagnosis and the health care system can be hard to figure out on your own, but there is help. The American Cancer Society Patient Navigation program offers you support with day-to-day concerns to help you stay on track with your treatment and care. Help with financial and insurance questions, prescription drug information as well as community resources, all available free to you and your caregivers.

Help with Appearance-related Effects of Treatment
Look Good…Feel Better® - Licensed volunteer cosmetologists teach cancer patients techniques to help restore their appearance and self-image during chemotherapy and radiation.

Breast Cancer Support
Reach to Recovery® - Trained breast cancer survivors provide one-on-one support and educatior to individuals dealing with the emotional and physical effects of breast cancer.

Help Getting To and From Cancer Treatment
Road to Recovery- The society provides assistance to help cancer patients get to and from their treatment appointments, including the Road to Recovery[SM] Program, where rides are provided by trained volunteer drivers.

Help Answering Health Insurance Questions
Health Insurance Assistance Program -
Information source for private health insurance, government-funded plans, options for the uninsured and financial issues. This service may be able to find sources of help, including health insurance risk pools and other resources.

Cancer Education Classes
I Can Cope® - This educational program for cancer patients and caregivers provides reliable information, peer support, and practical coping skills.

Online Community of Survivors and Caregivers
Cancer Survivors Network[SM] - Created by and for cancer survivors and their families, this "virtual" community is a welcoming, safe place for people to find hope and inspiration from others who have "been there." Services include pre-recorded discussions and personal stories from people with cancer and their loved ones, discussion boards, chat rooms, private and secure email, personal web pages, an Expression Gallery, and more. All are available at www.cancer.org

"**tlc"™ magalog -** A magazine and catalog in one, "tlc" supports women dealing with hair loss and other physical effects of cancer treatment. The magalog offers a wide variety of affordable products, such as wigs, hats, and prostheses, through the privacy and convenience of mail order.

Help with Lodging During Cancer Treatment
Hope Lodge®- Cancer patients who need treatment far from home sometimes face a problem: how to pay for a place to stay. The American Cancer Society may be able to help through our Hope Lodge program. Hope Lodges offer free, overnight housing for cancer patients while they are being treated for cancer. Our Hope Lodges offer a comfortable place where you can find support and friendship from others going through the same thing.

Assistance with Clinical Trials
Clinical Trials Matching Service - Free, confidential service helps find cancer clinical trials appropriate to a patient's medical and personal situation. In partnership with the Coalition of Cancer Cooperative Groups, this service may help find research studies testing new drugs or methods to prevent, detect or treat cancer.

Support for Men Fighting Prostate Cancer
Man to Man® - This comfortable, community-based setting for discussion and education provides men facing prostate cancer with support individually or in groups. Man to Man also offers men the opportunity to educate their communities about prostate cancer and advocate with lawmakers for stronger research and treatment policies.

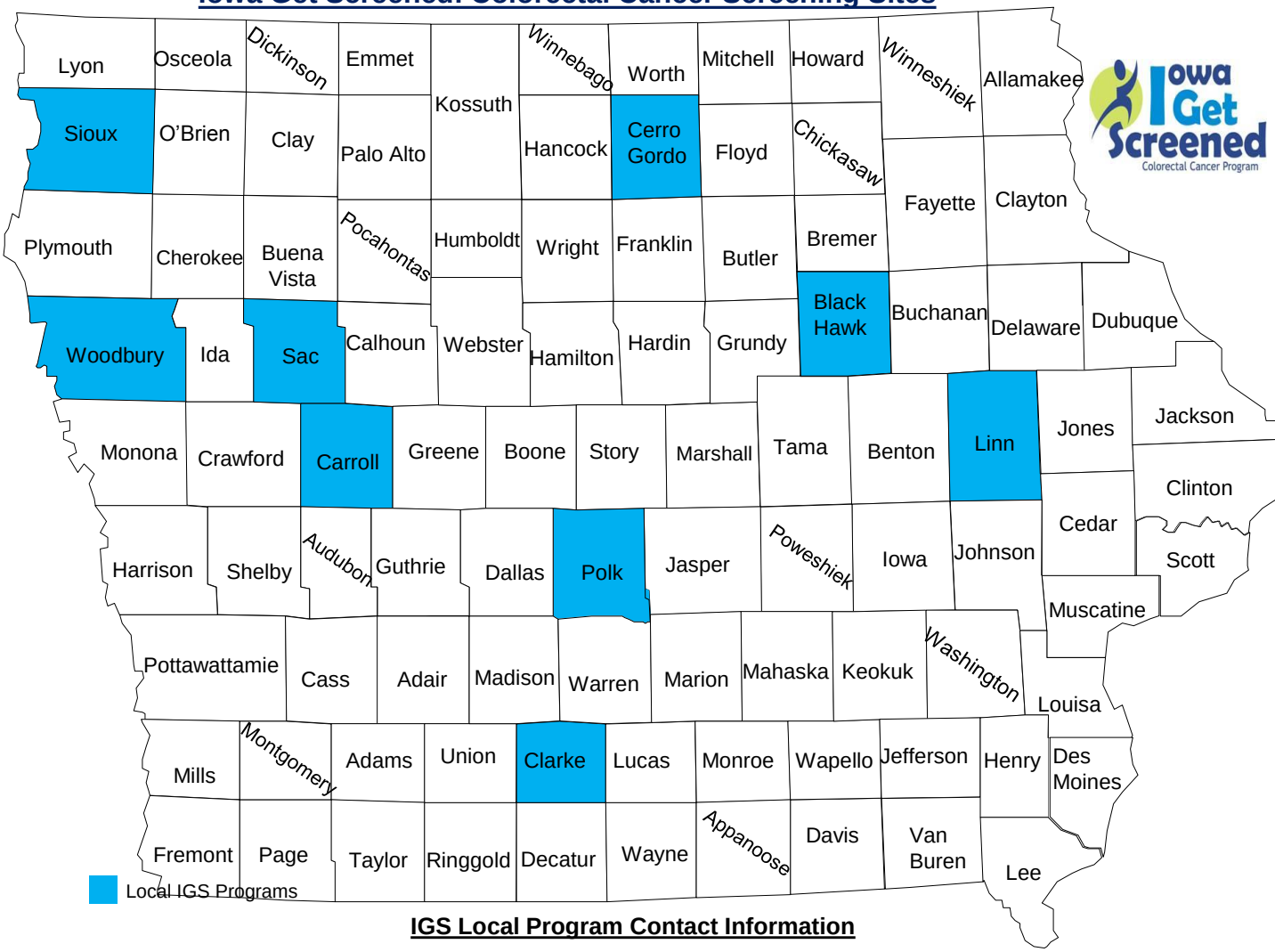
The American Cancer Society is the nationwide community-based voluntary health organization dedicated to eliminating cancer as a major health problem by preventing cancer, saving lives, and diminishing suffering from cancer, through research, education, advocacy and service.

American Cancer Society®

1.800.227.2345
www.cancer.org

Appendix I

Iowa Get Screened: Colorectal Cancer Screening Sites



IGS Local Program Contact Information

St. Anthony Home Health Agency
318 South Maple Street, Suite # 3
Carroll, Iowa 51401
712-794-5408

Cerro Gordo County Department of Public Health
22 N. Georgia Ave., Ste. 300
Mason City, IA 50401
641-421-9315

Promise Community Health Center
338 1st Avenue NW
Sioux Center, IA 51250-1875
712-722-1700

His Hands Free Medical Clinic/His Hands Ministries
400 12th Street SE
Cedar Rapids, IA 52403
319-862-2636

Linn County Health Department
501 13th Street NW
Cedar Rapids, Iowa 52405
319-892-6081

Polk County Health Department
1907 Carpenter Avenue
Des Moines, Iowa 50314
515-286-2192

Proteus Inc.
3850 Merle Hay Road
Suite 500
Des Moines, Iowa 50310
515-271-5306

Sac County Health Services
116 South State Street, Suite A
Sac City, Iowa 50583
712-662-4785

Clarke County Public Health
134 W. Jefferson
Osceola, IA 50213
641-342-3724

Black Hawk County Health Department
1407 Independence Ave
5th Floor
Waterloo, IA 50703
319-292-2225

Siouxland District Health Department
1014 Nebraska Street
Sioux City, IA 51105
712-279-6119

Colonoscopy only sites

St. Luke's Methodist Hospital
1026 A Ave NE
Cedar Rapids, Iowa 52406
319-369-7301

Programs funded by IDPH through CDC federal competitive grant number: 5U58DP002058